OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

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Legislative Coverage Mandates:
Standards for Application of Deductible, Coinsurance and/or Copayments

In general, deductibles, coinsurance and/or copayments[1] may be imposed for the benefits mandated by chapters 18, 19, 20 and 41 of title 27 of the General Laws so long as the deductible, coinsurance and/or copayment amount does not exceed the deductible, coinsurance and/or copayment amount imposed against the insured for other supplies, equipment, or physician office visits. The authority for the imposition of such deductibles, coinsurance and/or copayments can be found in the last subsection of the diabetes coverage mandates in chapters 18, 19, 20 and 41 of title 27 of the General Laws. For example, the diabetes mandates in § 27-19-35(b) contains the following language:

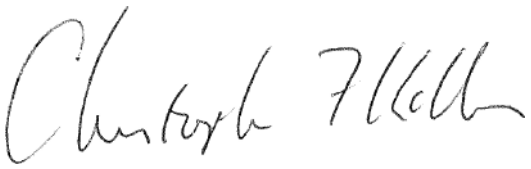
> Benefit plans offered by an insurer may impose co-payment and/or deductibles for the benefits mandated ***by this chapter***; however, in no instance shall the co-payment or deductible amount be greater than the co-payment or deductible amount imposed for other supplies, equipment or physician office visits. Benefits for services under this chapter shall be

[1] There is ample evidence that the General Assembly, at least in this context, used the words coinsurance and copayment interchangeably. Thus, this Office uses them interchangeably for the purposes of the mandate statutes.

> reimbursed in accordance with the respective principles and mechanisms of reimbursement for each insurer, hospital, or medical service corporation, or health maintenance organization.

Likewise, the diabetes mandates in §§ 27-18-38(c),[2] 27-20-30(b) and 27-41-44(b) contain similar language. Thus, unless a mandate-specific statute (or some other statute) places a limit on the deductible, coinsurance and/or copayment amount that can be charged for mandated coverage,[3] §§ 27-18-38(c), 27-19-35(b), 27-20-30(b) and 27-41-44(b) allow an insurer to charge deductible, coinsurance and/or copayment amounts for mandates so long as the deductible, coinsurance and/or copayment amounts charged are no higher than the deductible, coinsurance and/or copayment amounts charged for other things in the same policy.

Finally, it is important to note that the general rules set out in §§ 27-18-38(c), 27-19-35(b), 27-20-30(b) and 27-41-44(b) apply only to the coverage mandates contained in chapters 18, 19, 20 and 41, respectively. Mandates contained in other chapters establish their own requirements with respect to deductibles, coinsurance and copayments.



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[2] The second sentence of § 27-18-38(c) refers to "section" rather than "chapter", but is in all other respects similar to the second sentences in § 27-19-35(b), 27-20-30(b) and 27-41-44(b). This difference does not affect the interpretation of these statutes set out in this Bulletin.

[3] For example, the general rule established by § 27-18-38(c) is limited by language in specific mandate provisions contained in § 27-18-30, which limits coinsurance for infertility treatments to a maximum of 20%. Likewise, the language in § 27-19-55(a), which prohibits deductibles, coinsurance and/or copayments for early intervention coverage, supersedes the general language of § 27-19-35(b).